Copayment Changes Effective June 1, 2016

- Effective June 1, 2016, Medicaid members will have the following copayments.
  - Copayments may not exceed a combined limit of 5% of the family's household income quarterly. Copayments may not be applied once the household has met the quarterly cap.
  - Copayments may not be charged to the member until the provider's claim has been processed, the provider has been notified of payment, and the amount the member owes. Providers cannot deny services if the member is below 100% of the federal poverty level (FPL) and is unable to pay copayments. However, the member is still responsible for paying any copayments owed to the provider.
  - Members with income above 100% of the FPL will be responsible for a 10% copayment of the provider's reimbursed amount for any Medicaid covered service. Except for outpatient prescriptions which the member is responsible for a $4 copayment for preferred brand drugs, and an $8 copayment for non-preferred brand drugs.
  - Members with income below 100% of the FPL will be responsible for the new copayment amounts listed below:
    - Outpatient generic prescriptions will have no copayment. Preferred brand drugs will have a $4 copayment. Non-preferred brand drugs will have an $8 copayment.
    - Copayments for the following services will go from $3 to $4:
      - Dental,
      - Home health,
      - Licensed Professional Counselor (LCPC),
      - Psychologist,
      - Licensed Clinical Social Worker, and
      - Speech therapy.
    - Copayments for the following services will go from $2 to $4:
      - Audiology,
      - Hearing aids,
      - Occupational therapy,
      - Optician/Optometric, and
      - Physical therapy.
    - Copayments for public health clinic services will go from $1 to $4.
    - Copayments for the following services will go from $0 to $4:
      - Independent lab and x-ray,
      - Mental health clinic services provided by a licensed professional, and
      - Chemical dependency.
  - Members who do not have copayments are:
    - Under age 21;
    - Pregnant women;
    - American Indians/Alaska Natives who are eligible for or have received a service from a Tribal health, Urban Indian clinic, or Indian Health Service (IHS) provider;
    - Terminally ill members receiving hospice services;

- Members who are receiving services under the Medicaid breast and cervical cancer treatment category; and
- Inpatient in a hospital, skilled nursing facility, intermediate care facility, or other medical institution if the member is required to spend for the cost of care all but their personal needs allowance.

- The services listed below do not require copayments:
  - Emergency,
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT),
  - Family planning,
  - Eyeglasses purchased by Medicaid through a volume purchasing agreement,
  - Hospice,
  - Transportation,
  - Home and Community Based Waiver,
  - Provider preventable healthcare acquired conditions,
  - Generic drugs,
  - Approved preventive, and
  - Services where Medicaid is the secondary payer. If the service is not covered by the primary payer but is covered by Medicaid, copayment will be applied.
- Members may need to pay more than one copayment amount, depending on the Medicaid services received. For example, a visit may result in the following copayments, $4 for x-rays, $4 for lab work, $4 for a doctor visit, and $4 for a facility fee (depending on the place of service) for a total copayment amount of $16.

This notice as well as the Montana Medicaid and Healthy Montana Kids *Plus* Member Guide can be found at http://dphhs.mt.gov/MontanaHealthcarePrograms. For questions, call the Medicaid Member Help Line at 1-800-362-8312 Monday through Friday 8 a.m. to 5 p.m.